

Authorization For Release of Protected Health Information

By executing this authorization, I am consenting to the release of protected, or confidential, health information. I am voluntarily executing this authorization.

AUTHORIZATION:

I, _____, Social Security Number, _____ authorize the Sheet Metal Workers Local 38 Insurance and Welfare Fund ("the Plan") to disclose information related to my eligibility for benefits under the Plan to Sheet Metal Workers Local 38 (the "Union").

This authorization will expire upon my resignation from the Union.

I have read and understand the following statements:

- I may revoke this authorization in writing at any time prior to its expiration date, with the understanding that any such revocation will not affect any releases of protected health information made before the Plan received the revocation.
- Upon request, the Plan will provide me with a copy of this signed authorization.
- I am not required to sign this authorization in order to receive benefits under the Plan.
- Once information is disclosed by the Plan pursuant to this authorization, it may be redisclosed by the person receiving the information and no longer considered protected health information.
- This Authorization may not be used to release information contained in psychotherapy notes.

SIGNATURE:

Signature

Date